CITY OF RIVERSIDE
FAMILY, MEDICAL, AND/OR PREGNANCY DISABILITY LEAVE
MEDICAL CERTIFICATION

Employee Information

*(To be completed by employee**C**fill out all information that applies.)*

Employee_____ Date_____

ID #_____ Department/Division_____

Phone Number (Home)_____ Phone Number (Work)_____

Current Address_____

Position_____

Name of family member with serious health condition (if different than employee)_____

Date Condition Began_____ Date Condition Expected to End_____

Date Leave Commenced_____ Date of Planned Return_____

Medical Release

(To be completed by employee)

I authorize the release of any medical information necessary to process my request for Family and Medical Leave.

Employee Signature_____ Date_____

Medical Certification for Leave

(To be completed by health care provider)

The federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) defines Aserious health condition.@ Does the patient=s condition qualify under any of the categories listed on the **reverse side** of this form? If so, check the appropriate category:

(1) ❑ (2) ❑ (3) ❑ (4) ❑ (5) ❑ (6) ❑

Explanation of extent to which employee is unable to perform the essential functions of his or her job, or is needed to care for an ill spouse, child, or parent._____

Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the normal work schedule in order to deal with the serious health condition of the employee or family member?

❑ Yes ❑ No If yes, comment below and include recommended work schedule.

Health Care Provider Signature_____ Date_____

Health Care Provider Name_____ Office Phone_____

(Please Print)

Medical Certification to Return to Work

(To be completed by health care provider)

I have examined the employee whose name appears at the top of this page and certify that s/he is able to return to work and perform all essential job functions.

Health Care Provider Signature_____ Date_____

Health Care Provider Name_____ Phone Number_____

Health Care Provider Comments

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

(1) Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

(2) Absence Plus Treatment

(a) A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(1) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

(3) Pregnancy

(NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA, but not under CFRA.)

Any period of incapacity due to pregnancy, or for prenatal care.

(4) Chronic Conditions Requiring Treatment

A chronic Condition which:

(a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider.

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

(5) Permanent/Long-term Conditions Requiring Supervision

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

(6) Multiple Treatment (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).